HILLSIDE FAMILY HEALTH CLINIC, PA. ADULT

CATHY POWERS, FNP REGISTRATION PACKET

Patient Information			
Date			Phone
Name:			Social Sec:
Please use your legal name. Last	First	Middle	
Address			P.O. Box
City:		State:	Zip:
Sex: □ Male □ Female	Age:	Birthday:	Marital Status: □Single □Married □Divorced □Separated □Widowed
Employment:			Occupation:
Email:			
Referred By:			
In case of Emergency			
Name			Phone

Financial Payment - Please give your insurance card to the Receptionist		
Parent/ Guardian/ Responsible Party:		
Last	First	Middle
Relationship to patient:	Birthday:	Social Security:
Address		P.O. Box
City:	State:	Zip:
Insurance Company:	Group Number:	Member ID:
Please list all previous Health Care Providers:		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that Hillside Clinic only estimates my benefits and I am financially responsible for any balance not covered by my insurance carrier. If a current and accurate insurance card and/or letter is not presented at time of visit, all services are payable at time of service. I also authorize Hillside Family Health Clinic or insurance Company to release any information required to process my claims. I also agree to office policies and privacy practices provided to me for review. (copy available upon request) in addition, I authorize Hillside Family Health Clinic to a Medication History Review.

Parent/ Guardian/ Responsible Party Signature:

Date:

Hillside Family Health Clinic

Patient and Financial Policy's

Welcome to our medical home. Hillside Family Health Clinic is directed by Dr. Thomas Sames, MD, and our nurse practioners include Cathy Powers, our owner, and Leslie Hayes. Upon on arrival you will fill out information about yourself that will be entered into our electronic medical data base and your photo will be taken for a record on your chart. Your information is confidential and will not be seen by other patients or visitors. As in most clinics, appointments are seen first, walk-ins are worked in as time allots. There are several staff members in the clinic and each of them will be preparing a place for each patient, so that we give you "quality of care as quickly as possible." We regret the inconvenience, but due to heavy patient loads, we may have minimum of 2 hour wait time. Thank you for your patience.

We are a general medical clinic and are open Monday- Friday 8a-6p and walk-ins may be available from 8a-10a and 1p-4p on Monday- Thursday. We do take most insurance but do not take *workman's' comp or auto accident claims.* If you have *workman's' comp,* we will give you a referral to another clinic. Your insurance card and Drivers Licenses is required at each visit for Red Flag Identity Law. We will also require the patient's social security number for all appointments, labs and referrals. Without this information we will not be able to see you. If you have questions about insurance or billings in general please contact our billing agent at naguire@hillsidefamilyhealth.com or 806-206-1494.

This clinic is a certified hub facility and has been selected to give government and immigration physicals. We are also designated for foster care, Medicaid, Chips, STAR and CCHN special children.

To establish as a patients you will be scheduled for a complete physical. This includes blood work a urine drug screen, and a pap for of age females. You will be given a lab order 3 days before your physical and the results will be discussed with you and a plan of care established. Medications will be refilled according to the needs of each patient. Refills are processed on the computer between 9a-5p Monday - Thursday and on Friday from 9a-12n. We do not fill prescriptions over the weekend or on holidays.

We also will sign the patient up for a Portal Account, this account will give you access to your medical records, medicine refills, and request for appointments. By agreeing to this form you also agree to Hillside Family Health Clinic or any contracted agent or representative to contact you by phone, cell phone, email or any other wireless device, regarding any medical concerns, prescription or testing issues, or account and billing collections.

We have a contract with Texas public health department to provide vaccine for children. This will be given to those children who meet the eligibility standards. All others are required to pay full price for vaccine. The cost for those eligible is $22.00 per child. You must have a current shot record and the child's social security number to receive shots. At the time of the child's visit, you will be asked to sign permission to give your child the vaccine and to place your child's records on the Immtrac Registry. This makes sure that no matter where you go in Texas, your child's shot record will be available. We also provide yellow fever shots and other travel vaccine.

By signing the bottom of this form you agree to our financial policy. And you will also have some attached forms that need to be signed to be seen here. One is a HFCA form to file your insurance, Immtrac Registry and Vaccine Eligibility. If insurance is not available please ask about our Sliding Scale Program. You are also asked to decide who you want your information to be shared. We take cash, visa, master card and other debit cards. Our charges vary according to the type of service. Please ask the receptionist, if you have questions about the cost of the visit. The cost of the visit will increase or decrease according to the number of procedures required to help you get well. *We do not take checks.*

Patient Name

_____

Patient/Gaurdian Signature

Hillside Family Health Clinic, PA
7130 Bell St
Amarillo, Texas 79109
(806)373-4010

Financial Policy

Dear Patient/Guardian,

By signing the red HICFA form attached, you are legally responsible for all charges whether you have insurance or not. (This includes Medicaid, STAR, Chip/Superior). If your insurance does not pay, you will be charged whatever they do not pay. You also must pay your co-pay before being seen. If you have an insurance card and/or letter, it is your responsibility to make sure Cathy Powers, FNP or Thomas Sames M.D. is listed as a provider. When you give us your personal information, please make sure they are correct or the insurance company will not pay. Please consider this information carefully before signing. Once you have signed this document, you have agreed to its terms. This document will be kept on file and a new one will only be required if you change anything on your personal information. It is your prerogative not to sign. However, if you cannot sign, then we cannot see you as a patient.

Sincerely Yours

Financial Management

HILLSIDE FAMILY HEALTH CLINIC

THIS FORM MUST BE FILLED OUT BEFORE SEEING THE PROVIDER

CHILD HEALTH HISTORY

Patient Name:_____ Date of Birth: _____

Authorization for Review of Medical Records

The Health Insurance Portability and Accountability Act (HIPPA) require the patient (or parent, guardian or legal representative) to consent for others to look at the patient Medical Records. Please write the names below of relatives or friends, 18 years old or older, that can have access to the patient medical records. These will be the only people to look at or receive information about your health care. **HFHC will not disclose information to anyone other then the parent, guardian, or legal representative for minors, that are not listed below.**

Full Name:	Relationship to Patient:

Authorization for Medical Treatment of Minors

By signing this form, the patient parent, guardian, or legal representative give the following people permission to obtain and order medical treatment for this patient. They are of age (18 years or older) to make medical treatment decisions while the parent, guardian, or legal representative is absent, they may also sign any and all medical paperwork so that the patient can receive proper and prompt medical treatment. This is valid until a written notice states otherwise. **HFHC will not allow the patient to be seen without a parent, guardian, or legal representative unless they are listed below or have written permission.**

Full Name:	Relationship to Patient:

Patient [Parent, Guardian, or Legal Representative] Signature

Date

HILLSIDE FAMILY HEALTH CLINIC

THIS FORM MUST BE FILLED OUT BEFORE SEEING THE PROVIDER

CHILD HEALTH HISTORY

Patient Name (PRINT): _____SSN:_____DOB:_____

is requesting that Hillside Family Health Clinic, PA obtain health information **FROM** the person/company/agency/facility listed below.

Name:	
Organization Name:	
Address:	
Phone Number:	

The information to be disclosed relates to service dates beginning _____ and ending _____.

□ Entire Medical Record	□ Medication List	□ Physical Therapy Notes
□ Demographic Information	□ Immunizations	□ Occupational Health Record
□ History & Physical	□ Test Results	□ Other:
□ Medical/ Surgical History	□ Other Assessments	
□ Physician Office Notes	□ Discharge Summary	

The purpose of the disclosure: *("Request of the individual" is sufficient for patient-initiated releases)*

□ Request of Individual	□ Change of Provider	□ Legal Investigation
□ Referral to Specialist	□ Insurance	□ Other:
□ Continuing Care	□ Workers Comp	

Conditions and Notifications:
By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to

Hillside Family Health Clinic, PA.
Ph: 806-373-4010
Fax: 806-331-6373

Cathy Powers, FNP
Thomas Sames, MD

I understand that I may revoke this consent (in writing) at any time except to the extent that action has been take in reliance on it. This consent will expire 180 days after my signature unless otherwise specified.

_____ _____

Patient [Parent, Guardian, or Legal Representative] Signature Date

Additional Information:

HIPAA Notice of Privacy Practices
Revised 2016

Hillside Family Health Clinic
7130 S Bell St
Amarillo TX, 79109
(806-373-4010)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your

protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint. HFHC Compliance officer is:

Cheraye LeGrand
806-373-4010
caguirre@hillsidefamilyhealth.com

Effective 04/14/2003 Provided By HCSI
Revised 07/19/2016

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices

Patient Name (print) /Paciente Nombre (escribe) Date

Patient Signature/Guardian Signature/ Firma del paciente firma de madre/tutor fecha
Date

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. RESERVED FOR NUCC USE
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.	33. BILLING PROVIDER INFO & PH # ( ) a. b.

Hillside Family Health Clinic

Patient Name_____ DOB___/___/_____ Date___/___/_____

*In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The **Health Care Consumer (HCC) –Health Care Provider (HCP)** relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.*

Patient Name _____ Gender ◯M ◯F

If the person filling out this paperwork is not the patient, please write your name, your relationship to the patient, and the reason for filling out the form for this patient.

Name_____Relationship_____Reason_____

Reason for Visit_____

Patient's Personal Contact Information (Address and Phone)

_____ Home Phone_____

_____ Work Phone_____

Emergency Contact (Address and Phone)

_____ Home Phone_____

_____ Work Phone_____

Insurance Information (Insurance Company, Policy #, Contact #)

_____ Contact Number_____

Policy Number_____ Fax (if known)_____

Additional or Secondary Insurance Information

_____ Contact Number_____

Policy Number_____ Fax (if known)_____

Please list all medications you are taking. Include over the counter medications, herbs & vitamins.

Medication Name	*Dose*	*Last Taken*	*Medication Name*	*Dose*	*Last Taken*

Please list and describe allergic reactions you have to food, medications, or insect bites.

Check if you are allergic to **Shellfish___ IV Contrast Dye___ Penicillins___**

Food, Medication and Insect Allergies Reaction

_____ _____

Patient Name_____ DOB___/___/_____ Date___/___/_____

Do you have a history of smoking? ◯**Yes** ◯**No** If yes,_____# packs per day, for how long_____

Have you ever chewed tobacco? ◯Yes ◯No

Have you smoked pipes or cigars? ◯ Yes ◯No If yes how many cigars or bowls___per day/week

Have you quit? If so, when? ◯ Yes ◯ No _____

Have you considered quitting? ◯ Yes ◯ No If yes, have you set a date to quit? __Yes __No
Have you tried quitting? ◯ Yes ◯ No If yes, what is the longest time period you quit? ____

Do you have a history of alcohol use? ◯ Yes ◯ No If yes, specify_____# drinks per day/week
1 "drink" is equal to 12 oz can of beer, 1.5 oz liquor(80 proof) or 5 oz wine
Have you ever experienced a blackout, or loss of consciousness due to alcohol? ◯Yes ◯No
Have you needed to drink to prevent shaking, sweating and becoming irritable? ◯Yes ◯No
Have you been arrested or ticketed for DUI (Driving Under the Influence)? ◯Yes ◯No
Have you been in any motor vehicle accidents in the past 12 months? ◯Yes ◯No

Do you use drugs for recreational purposes? ◯Yes ◯No
If yes, check all that apply __ Amphetamines __Cocaine __Marijuana __Heroin __Inhalants __LSD
Method of delivery you chose __Ingestion __Injection __Inhalation
How much would you use_____
How long did you use drugs _____
Have you quit? ◯Yes ◯No If so, when_____
Have you taken drugs to prevent shaking, sweating or becoming irritable? ◯Yes ◯No
Have you ever had a problem with addiction to prescription pain medication or benzodiazepines? ◯Yes ◯No
If yes, specify which drugs and when_____

Have you traveled in the past year? ◯Yes ◯No
If so, please describe where, when and how long you were there.

Travel Destinations OUTSIDE the United States	**Dates spent at this destination**
_____	_____
_____	_____
Travel Destinations INSIDE the United States	**Dates Spent at this destination**
_____	_____
_____	_____

Patient Name_____ DOB___/___/_____ Date___/___/_____

Do you exercise? ◯***Yes*** ◯***No*** *If yes how many times a week _____*
If yes, have you ever broken bones or sustained and injury as a result of falling? ◯Yes ◯No

Have you had any of the following vaccinations? Check all that apply and specify when last received.

◯Yes ◯No Influenza _____
◯Yes ◯No Pneumonia_____
◯Yes ◯No Tetanus_____
◯Yes ◯No BCG_____
◯Yes ◯No HPV (Gardasil)_____
◯Yes ◯No Varicella_____

Patient Name_____ DOB___/___/_____ Date___/___/_____

If you are female, have you ever been pregnant? ◯Yes ◯No
Number of pregnancies____ Number of live births____ Number of miscarriages____ Number of abortions____
Age of onset of menstrual cycle____ **Age of onset of menopause____**
Have you ever taken birth control pills, or used birth control patches or implants? ◯Yes ◯No
If yes, what did you take and for how long? _____
Have you ever been on hormone replacement therapy? ◯Yes ◯No
If yes, what did you take and for how long? _____

Have you ever had an IUD? ◯**Yes** ◯**No** *if yes, was it removed?* _____ *When*_____

Past Medical History Please check all that apply.

Adrenal Dysfunction ◯**Yes** ◯**No**
Alzheimer's ◯**Yes** ◯**No**
Amyotrophic Lateral Sclerosis ◯**Yes** ◯**No**
Anorexia or Bulimia ◯**Yes** ◯**No**
Anxiety Disorder ◯**Yes** ◯**No**
Arteriovenous Malformations ◯**Yes** ◯**No**
Arthritis ◯**Yes** ◯**No**
Asthma ◯**Yes** ◯**No**
Autoimmune Disease ◯**Yes** ◯**No**
Bipolar Disorder ◯**Yes** ◯**No**
Bleeding Disorder ◯**Yes** ◯**No**
Cataracts ◯**Yes** ◯**No**
Stroke ◯**Yes** ◯**No**
Chemotherapy *If yes, state when* ◯**Yes** ◯**No**

Claudication ◯**Yes** ◯**No**
Clotting Disorder ◯**Yes** ◯**No**
Congenital Heart Defects ◯**Yes** ◯**No**
Coronary Artery Disease ◯**Yes** ◯**No**
COPD ◯**Yes** ◯**No**
Cystic Fibrosis ◯**Yes** ◯**No**
Depression ◯**Yes** ◯**No**
Diabetes ◯**Yes** ◯**No**
Dialysis ◯**Yes** ◯**No**
Eclampsia or Pre-eclampsia ◯**Yes** ◯**No**
Endocarditis ◯**Yes** ◯**No**
Endometriosis ◯**Yes** ◯**No**
End Stage Renal Disease ◯**Yes** ◯**No**
Erectile Dysfunction ◯**Yes** ◯**No**
Esophageal Dysfunction ◯**Yes** ◯**No**
Fibromyalgia ◯**Yes** ◯**No**
Gallstones ◯**Yes** ◯**No**
Gastritis or Gastric Ulcer ◯**Yes** ◯**No**
GERD ◯**Yes** ◯**No**
Glaucoma ◯**Yes** ◯**No**

Irregular Heart Rhythm ◯**Yes** ◯**No**
Kyphosis ◯**Yes** ◯**No**
Liver Dysfunction ◯**Yes** ◯**No**
Kidney failure/dysfunction ◯**Yes** ◯**No**
Cancer ◯**Yes** ◯**No**
what type of cancer_____?

Mania ◯**Yes** ◯**No**
Muscular Dystrophy ◯**Yes** ◯**No**
Heart Attack ◯**Yes** ◯**No**
Narcolepsy ◯**Yes** ◯**No**
Obstructive Sleep Apnea ◯**Yes** ◯**No**
Organ Transplant *Please describe* ◯**Yes**◯**No**

Osteoporosis ◯**Yes** ◯**No**
Pancreatitis ◯**Yes** ◯**No**
Periodic Limb Movement Disorder ◯**Yes** ◯**No**
Peripheral Artery Disease ◯**Yes** ◯**No**
Personality Disorder ◯**Yes** ◯**No**
Pituitary Dysfunction ◯**Yes** ◯**No**
Polycystic Ovarian Syndrome ◯**Yes** ◯**No**

Pulmonary Artery Hypertension ◯**Yes** ◯**No**
Pulmonary Fibrosis ◯**Yes** ◯**No**
Radiation Therapy *If yes,explain* ◯**Yes** ◯**No**

Recurrent Infections ◯**Yes** ◯**No**
Restless Leg Syndrome ◯**Yes** ◯**No**
Sarcoidosis ◯**Yes** ◯**No**
Schizophrenia ◯**Yes** ◯**No**
Scleroderma ◯**Yes** ◯**No**
Scoliosis ◯**Yes** ◯**No**
Seizure Disorder ◯**Yes** ◯**No**

Patient Name_____ DOB___/___/_____ Date___/___/_____

Heart or Valve Defects ◯**Yes** ◯**No**
Hemochromatosis ◯**Yes** ◯**No**
Hemorrhoids ◯**Yes** ◯**No**
Hepatitis ◯**Yes** ◯**No**
HIV or AIDS ◯**Yes** ◯**No**
Hypertension ◯**Yes** ◯**No**
Hyperthyroidism ◯**Yes** ◯**No**
Hypertension ◯**Yes** ◯**No**
Hyperthyroidism ◯**Yes** ◯**No**
Hypotension ◯**Yes** ◯**No**
Hypothyroidism ◯**Yes** ◯**No**
Inflammatory Bowel Disease ◯**Yes** ◯**No**

Sickle Cell ◯**Yes** ◯**No**
Sjogren ◯**Yes** ◯**No**
Skin Disorders ◯**Yes** ◯**No**
Thalassemia ◯**Yes** ◯**No**
Thrombocytopenia ◯**Yes** ◯**No**
Thrombophilia ◯**Yes** ◯**No**
Transfusions ◯**Yes** ◯**No**
Tuberculosis *If yes, have you been treated*? ◯**Yes**◯**No**

Urinary Retention/Urgency ◯**Yes** ◯**No**
Vasculitis ◯**Yes** ◯**No**
Visual Defects ◯**Yes** ◯**No**

Vocal Cord Dysfunction/paralysis ◯**Yes** ◯**No**

Please list all surgical procedures you have had. Include surgeon and date of surgery.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family Medical History *Please list all known medical problems in your immediate family.*
(specify M=Mother, F=Father, B=Brother,S=Sister,SO=Son,D=Daughter,GM=Grandmother,GF=Grandfather)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Additional Information you feel may be helpful for your healthcare provider to know.

_____
_____
_____
_____
_____
_____
_____

AUDIT: The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written and record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about

your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol? (1) Never (skip to Questions 9 and 10) (2) Monthly or less (3) 2 to 4 times a month (4) 2 to 3 times a week (5) 4 or more times a week	2. How many drinks containing alcohol do you have on a typical day when you are drinking? (1) 1 or 2 (2) 3 or 4 (3) 5 or 6 (3) 7, 8, or 9 (4) 10 or more
3. How often do you have six or more drinks on one occasion? (1) Never (2) Less than monthly (3) Monthly (4) Weekly (5) Daily or almost daily	4. How often during the last year have you found that you were not able to stop drinking once you had started? (1) Never (2) Less than monthly (3) Monthly (4) Weekly (5) Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (1) Never (2) Less than monthly (3) Monthly (4) Weekly (5) Daily or almost daily	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (1) Never (2) Less than monthly (3) Monthly (4) Weekly (5) Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking? (1) Never (2) Less than monthly (3) Monthly (4) Weekly (5) Daily or almost daily	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (1) Never (2) Less than monthly (3) Monthly (4) Weekly (5) Daily or almost daily
9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes but not in the last year (4) Yes during the last year	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes but not in the last year (4) Yes during the last year
	Record total of specific items here

Provider Signature (firma de proveedor): _____

Scoring for AUDIT

Risk level	Intervention	AUDIT score*
Zone I	Alcohol education	0–7
Zone II	Simple advice	8–15
Zone III	Simple advice plus brief counseling and continued monitoring	16–19
Zone IV	Referral to specialist for diagnostic evaluation and treatment	20–40

*The AUDIT cut-off score may vary slightly depending on the country's drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Clinical judgment should be exercised in cases where the patient's score is not consistent with other evidence, or if the patient has a prior history of alcohol dependence. It may also be instructive to review the patient's responses to individual questions dealing with dependence symptoms (Questions 4, 5 and 6) and alcohol-related problems (Questions 9 and 10). Provide the next highest level of intervention to patients who score 2 or more on Questions 4, 5 and 6, or 4 on Questions 9 or 10.

From: Babor T, Higgins-Biddle J, Saunders J, Monteiro M. The Alcohol Use Disorders Identification Test. Guidelines for use in primary care. 2nd ed. Geneva, Switzerland: World Health Organisation, 2001.

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✔" to indicate your answer)

	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
7. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
8. **Thoughts that you would be better off dead or hurting your self in some way**	0	1	2	3
9. **Thoughts that you would be better off dead or hurting your self in some way**	0	1	2	3

If you checked off <u>any</u> problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

For office coding _____+_____+_____+

Total Score _____ =

Checked by licensed provider

_____ Referral made to mental health if score is >12

Signature of licensed provider _____ Date _____

ADULT PERTUSSIS SCREENING FORM
Forma de deteccion de pertussis adulto

It is important to evaluate our risk of contracting pertussis, commonly known as whooping cough; adults can contract this disease and potentially pass the infection on to very young susceptible infants. This form asks a few simple questions that will help to determine if you are at increased risk. Help prevent the spread of pertussis by protecting yourself.

Es importante evaluar nuestro riesgo de contraer la tos ferina, conocida comúnmente como la tos ferina; los adultos pueden contraer esta enfermedad y potencialmente transmitir la infección a los bebés susceptibles de muy corta edad. Esta forma hace algunas preguntas sencillas que le ayudarán a determinar si usted está en mayor riesgo. Ayuda a prevenir la propagación de la tos ferina por protegerse.

Are you at increased risk to contracting and transmitting pertussis? Get protected today! **Usted esta en mayor riesgo de contaer y transmitir a los ferina? Consige protegida hoy!**

Circle the answer that best fits you (**circule la respuesta mejor)**

1. Are you 11-64 years of age? (tiene edad de 11-64?)	Yes	No
2. Has it been more than 2 years since your last tetanus vaccine? (ha sido mas de 2 anos desde su ultima vacuna de tetanus?	Yes	No
3. Do you anticipate having close contact with infants 12 months of age or younger (eg, mother, father,sibling, or grandparent)? ¿usted anticipa tener contacto cercano con bebés de 12 meses de edad o menos (por ejemplo, madre, padre, hermanos o abuelos)?	Yes	No
4. Are you an employee in a school or child-care setting (eg babysitter, teacher, teacher's aide or child-care provider)? ¿Es usted un empleado en una escuela o de cuidado de niños (por ejemplo, niñera, profesor, ayudante o de cuidado de niños de proveedores del maestro)?	Yes	No
5. Are you a health care worker (eg, doctor, nurse, dentist, therapist, aide, technician, medical student, or hospital employee? Having direct patient contact? ¿Es usted un trabajador de la salud (por ejemplo, médico, enfermera, dentista, terapeuta, ayudante, técnico, estudiante de medicina, o empleado del hospital? Tener contacto directo con pacientes?	Yes	No

If you answered "yes" to any of these questions, ask your health care professional if a Tdap Vaccine is right for you.

Si usted contestó "sí" a cualquiera de estas preguntas, consulte a su profesional de la salud si una vacuna Tdap es adecuado para usted.

Patient Name/nombre de paciente _____

DOB/ fecha de nacimiento _____

Patient Signature/ firma de paciente _____

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

Last Name

First Name **Middle Name**

Date of Birth **Gender:** ☐ **Male** ☐ **Female**

Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7). The ImmTrac2 Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry, ImmTrac2. Once in ImmTrac2, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

I understand that I may withdraw this consent at any time.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative):

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 ▪ (512) 776-7284 ▪ Fax (866) 624-0180 ▪ www.ImmTrac.com

Texas Department of State Health Services ▪ ImmTrac2 Group – MC 1946 ▪ P. O. Box 149347 ▪ Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

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